Is Your Health the Nation's Business?

FM-30 CI ROUNDTABLE

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by

THE AMERICAN HISTORICAL ASSOCIATION

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Is Your Health the Nation's Business?

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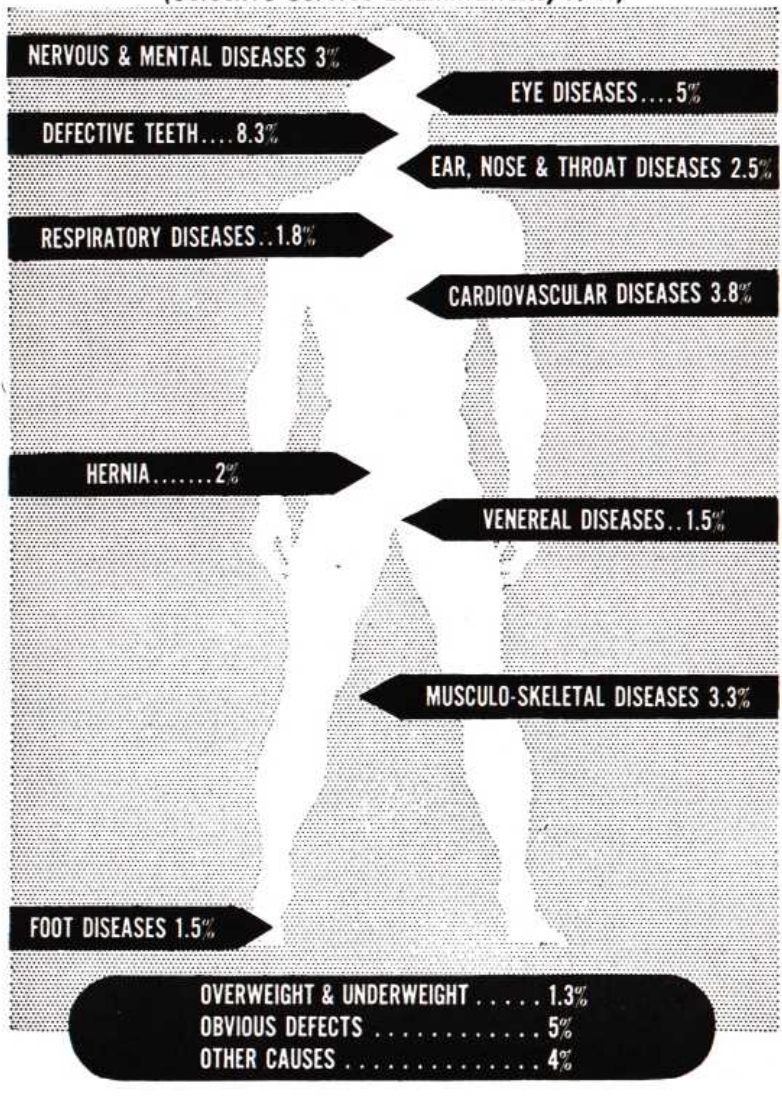
(Selective Service Examinations, 1941)



IS HEALTH YOUR OWN BUSINESS OR THE NATION'S?

WHAT ARE the achievements of American medicine? Do its services reach the people who need them? Is the battle against sickness a public question like the battle against illiteracy? What role should local, state, and national government agencies play in supplementing private effort?

A widely accepted answer to the first two questions was given by the Senate Subcommittee on Wartime Health and Education (the Pepper Committee) when it said in its report: "The quality of American medicine at its best is very high. Unfortunately, American medicine at its best reaches only a relatively small part of the population."

The other questions—on the stake of the general public in preventing ill health and the role of government in the struggle against disease—are not new ones. Community responsibility for public health has long been recognized in laws and ordinances for sanitation, food inspection, and the prevention of communicable diseases. Does public interest also extend to bringing better medical care of all kinds to more people at less cost? This pamphlet presents some of the most widely discussed programs for national health and the arguments pro and con touching them.

What are some of the facts and figures that have made the issues seem too important to be left to private effort or to public health agencies as they now exist?

In 1935, more than 23 million people in the country had a chronic disease or a physical impairment. In spite of tremendous advances in medical science, the death rate among low-income groups in our large cities is still as high as the national rate fifty years ago. Deaths among mothers and babies could be cut about one-third if all got good medical care.

The fact that struck hardest and startled the public most was the revelation from the Selective Service figures that 30 percent of the men of military age were unfit for general military duty.

The gap between what modern medicine has to offer and the kind of medical care people actually receive is usually blamed on two things: people's inability to pay for good medical care under present arrangements, and the way health services are organized.

Modern medicine comes high

Modern first-class medical care is necessarily an expensive commodity. Many people cannot meet its full cost regardless of the method of payment. The cheapest medical and dental service compatible with good quality and high standards would probably cost about $150 a year for the average-sized family. But studies of family spending show that most families under the $2,000 level—or about half our population—simply cannot pay a full $150 a year for this purpose. If their medical needs are to be fully met, such people need assistance. As it stands today, people in low-income groups, though they have twice as many days of sickness as the well to do, receive only about half as much physicians' care.

Not only does good medical care cost a lot, but the need for it cannot be predicted. If you can't foretell when illness will strike or how serious it will be, how can you prepare to meet

its costs? Many a family able to budget $150 a year for medical expenses is staggered or financially crushed for years to come by the cost of a single serious illness. Moreover, having to pay a fee for the doctor's services is a frightening prospect to people whose incomes barely cover living expenses—so they often put off going to the doctor. Thus they lose the benefits of preventive measures, early diagnosis and treatment, and perhaps have to pay more in the end.

Fortunately, though no one can predict when or how seriously an *individual* will be sick or injured, the frequency of such ills can be figured in advance with reasonable accuracy for *groups* of people. These facts led the Pepper Committee to conclude:

> "The 'pay-as-you-go' or fee-for-service system, which is now the predominant method of payment for medical services, is not well suited to the needs of most people or to the widest possible distribution of high-quality medical care. It tends to keep people away from the doctor until illness has reached a stage where treatment is likely to be prolonged and medical bills large. It deters patients from seeking services which are sometimes essential, such as specialist care, laboratory and X-ray examinations, and hospitalization. Individuals with low incomes, whose need is greatest, are more likely to postpone or forego diagnosis and treatment."

Health, wealth, and geography

Cost is widely recognized as a barrier between individual people and the medical services they need. Another difficulty is that people in some parts of the country don't have enough medical services at hand—regardless of price or ability to pay. The extent of health services actually available in different parts of the country varies according to the wealth of whole communities. Counties, cities, and states which are well off have enough doctors, nurses, and hospitals, and adequate public health facilities; those which are poor have desperately few.

In New York State before the war, for example, there was one doctor in practice for every 500 people, while in Mississippi

Five states and the District of Columbia[1], whose average per capita income in 1940 was $814., had, per 10,000 population:

15.7 DOCTORS
6.9 DENTISTS
32.6 NURSES
45 HOSPITAL BEDS

Seven poorer states[2], whose average per capita income in 1940 was $303., had, per 10,000 population:

7 DOCTORS
2.3 DENTISTS
10.4 NURSES
24 HOSPITAL BEDS

1 *Rhode Island, District of Columbia, New York, New Jersey, Illinois, California.*

2 *Kentucky, West Virginia, North Carolina, South Dakota, South Carolina, North Dakota, Mississippi.*

there was one for 1,500—exactly three times the number of people to be served by each physician. Moreover, the density of population in Mississippi is about one-tenth that of New York, so that not only does each physician have more persons to serve, but on the average, he has to travel farther to serve them.

In New York there was one general hospital bed for every 200 people, but in Mississippi one to every 650. Variations between counties are even more striking—17 million people live in 1,300 counties that have no recognized general hospital at all. Thus, where communities are too poor to attract

sufficient doctors or to build and maintain other health facilities, not only do the needy have to go without necessary medical services, but so do those who can afford to pay but cannot seek care elsewhere.

Health services are unorganized

Even the best general practitioner cannot adequately cope with emergencies or with baffling and complicated cases if he does not have the resources of a well-equipped hospital within reach and does not have colleagues in surgery and the other specialties available when needed. Even where there are first-rate hospitals, the general practitioner may not have the right to use them. In Baltimore, for example, almost half the general practitioners cannot care for their patients in hospitals.

Specialists usually set up offices in cities of some size. They are not easily accessible to country doctors or country patients. Moreover, specialists are not as a rule organized to work in combination with general physicians. Such teamwork can be found, however, in many of the leading hospitals and clinics where medicine is taught and in the outstanding group practice clinics such as, for example, the Mayo Clinic.

In today's medical schools students are trained under a system of group medical practice, centered about a hospital where the best available equipment and techniques can be employed and where the combined skills of a variety of specialists can be brought to bear on a puzzling case. Yet when they graduate, they go out into a kind of isolated practice similar to that of their grandfathers' day. That this is professionally unsatisfactory to physicians is shown by the fact that over half the doctors in the Army stated that they would like to go into group practice on returning to civilian life.

To sum up the problems of American medicine, then: Americans receive the benefits of medical science in a very uneven manner, partly because of the high cost of modern

medicine, partly because medical services are not organized to serve everyone equally—regardless of where he happens to live or how much he can pay.

Clearly, then, the problem of paying for health services is very complex. Can some way be found for families to budget these costs and to assist those families which cannot reasonably afford the total costs? And can facilities for rendering health services be made more equally available in all parts of the country?

What's to be done?

President Roosevelt, in his "economic bill of rights" put before the nation early in 1944, included "the right to adequate medical care and the opportunity to achieve and enjoy good health." Wendell Willkie declared in 1944, "Complete medical care should be available to all." Secretary Wallace recently said, "Your federal and state governments have just as much responsibility for the health of their people as they have for providing them with education and police and fire protection." Governor Thomas E. Dewey appointed in 1944 a commission on medical care "in order to devise programs for medical care for persons of all groups and classes in New York State." In his special message of November 19, 1945 asking Congress to adopt a five-point national health program, President Truman said, "We should resolve now that the health of this Nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all its citizens deserves the help of all the Nation."

Thus leaders of both political parties have followed the demand of farm, labor, and business organizations and of the public at large, as shown in various opinion polls, for an improvement in the way medical care is distributed.

Some professional medical organizations echo the cry. The American Public Health Association, an organization of physicians, nurses, sanitary engineers, and others engaged in public

health work, adopted in the fall of 1944 an official policy which states that "a national program for medical care should make available to the entire population, *regardless of the financial means of the individual, the family, or the community*, all essential preventive, diagnostic and curative services." The American Dental Association has declared that "dental care should be available to all, regardless of income or geographic location." The American Medical Association, representing the majority of private practitioners and on the record as a conservative professional organization, now recognizes the fact that there is a problem in the distribution of medical care. Up to a few years ago, it often asserted that, except in isolated instances, everyone needing medical care was able to get it, by paying for it or through charity.

WHAT DO PEOPLE PROPOSE TO DO ABOUT THE SITUATION?

Although a great many people know that ways must be found so that everyone can secure good medical care more rapidly and pay for it more easily, there is no such agreement on just how this should be done. In particular, opinions vary a good deal on the government's role in the future of medical care. Some think no further government activity is necessary. Others think that the government must play a part, but differ as to how big that part should be. Proposals range from tax support for such limited purposes as school health programs, to a complete national health program paid for through national health insurance and general tax funds.

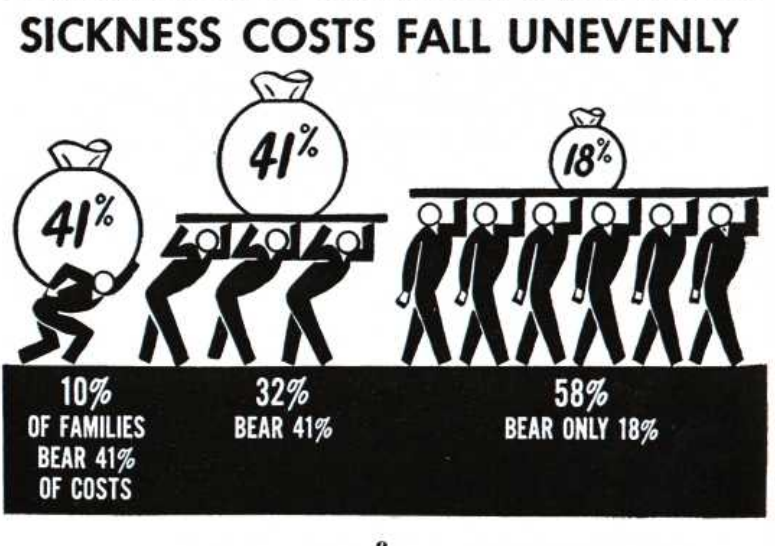
Hands off, Government!

Present governmental activities in providing health services are generally accepted. Each American citizen spends about a dollar a year for control of contagious diseases, installation

of pure milk and water supplies, and other public health services. That dollar is considered a good investment. Though state-supported hospitals for mental illness and tuberculosis are sometimes criticized as insufficient, no one wants them eliminated. Rather, public pressure is for their improvement and expansion. So on through the long list of local, state, and federally supported health services.

Yet, at first, almost all tax-supported services met violent opposition from small groups whose interests were temporarily affected. When, for example, the testing of dairy cattle for tuberculosis as a means of keeping contaminated milk from the markets was proposed, dairymen bitterly opposed it. They said that any such measure would mean political control and regimentation.

Similar protests have frequently come from representatives of the medical profession, who usually oppose the extension of tax-supported health services. In 1944, for example, the governing body of the American Medical Association, while recognizing the need for improved early diagnosis and treat-



ment of tuberculosis, did not favor increased federal responsibility in this field, and refused to support a bill in Congress extending federal financial aid to the states for the control of tuberculosis. Aware that under present conditions over half the patients admitted to tuberculosis hospitals are already in an advanced stage of the disease, most public health experts considered this bill a vital measure toward the ultimate wiping out of tuberculosis. In spite of the position taken by the American Medical Association, Congress passed the law without a dissenting vote one week later.

The A.M.A. today is strongly opposed to any form of government-sponsored health insurance on the ground that it would bring political control of medicine and interfere with the personal relationship between patient and physician. For some years, the A.M.A. has held that the intimate bond between patient and physician is threatened or destroyed when the patient himself does not pay his doctor on a fee-for-service basis. Yet the A.M.A., yielding to public pressure for an easier way of meeting sickness costs, now supports voluntary health insurance run by commercial companies or by medical societies. This is a reversal of its position of ten years ago when the A.M.A. editorialized against proposals for voluntary health insurance as measures of "socialism and communism inciting to revolution." In July 1945 the A.M.A. declared its position in a program, summarized in a later section of this pamphlet.

Voluntary insurance

Voluntary insurance against the costs of hospitalization and physicians' services has, however, had a considerable development in the United States. The oldest of these insurance plans are those organized in certain industries, especially in mines and railroads, which often operate in remote regions where medical services are scanty. Usually, a monthly deduction of a dollar or two is made from employees' wages and a like

amount is often contributed by employers. These funds are then pooled and are used to pay for the medical care which may be needed by the employee. Employees' families are sometimes but not generally included. Few new plans of this type have been started in recent years, although one has received wide attention—that organized at the Kaiser shipyards on the West Coast.

The largest recent development in voluntary insurance has been for hospitalization, especially the "Blue Cross" plans approved by the American Hospital Association. Blue Cross subscribers are enlisted voluntarily from among employee groups in the community. Subscribers usually pay about $24 a year for insurance that covers hospitalization for employees and their families for a period of three to four weeks a year. The Blue Cross plans have expanded in the past ten years from less than a million subscribers to more than 18 million.

Plans have also been organized to insure the costs of physicians' services. These have not been so successful as the hospitalization insurance plans but have nevertheless grown so that they now cover about 4 or 5 million people, chiefly for services limited to surgical operations and obstetrics.

Voluntary insurance plans have also been developed for low-income farmers, under the sponsorship of the Farm Security Administration, and about 300,000 rural inhabitants are now included in them. Farm families generally pay about $25 to $50 a year in these plans and receive limited medical, surgical, and hospital care.

Commercial insurance companies have made some progress in selling policies to cover the costs of hospitalization, surgical and obstetrical care. Usually these policies are taken out by employers for their employees and their families, both employer and employee making monthly contributions to the fund. Approximately 8 million persons are now insured under such policies.

The success of voluntary efforts in providing insurance

against the costs of medical and hospital care has encouraged some groups to hope that all the major problems of health and medical care can be solved by voluntary measures, without the participation of government. As mentioned above, the American Medical Association takes this point of view. The United States Chamber of Commerce also advocates further trial of voluntary methods.

Others feel that voluntary insurance, whether it is under the auspices of nonprofit organizations of physicians and hospitals or of commercial insurance companies is too limited to solve the problem. They point to the fact that, despite the rapid growth of some plans, not more than 20 or 30 million persons are subscribers to such plans in the United States up to the present time and that the insurance coverage of even these persons is largely confined to surgical, obstetrical, and hospital care.

Furthermore they offer the objection that most existing voluntary insurance schemes include no general medical expenses, no preventive care, and little family care. They feel that such insurance provides no incentives for improving the quality of medical practice and that its cost limits its sale to a rather narrow section of the population. In the case of commercial policies, they say that it is no great bargain—companies on the average pay out in benefits only about half of what they receive in premiums.

Those who believe that voluntary efforts cannot fully solve the problem emphasize two difficulties encountered by such insurance. In the first place, voluntary plans, by their very nature, face the problem of securing and retaining subscribers. There is an inevitable tendency for healthy families to stay out of the plans and for those inclined toward illness to enter and remain in them. This fact is apt to bring about financial difficulties. Because of the spotty, uneven coverage of the population, the healthier families do not bear a full share of the costs. The second difficulty is that, if voluntary plans

charge high enough premiums to cover the costs of complete medical and hospital care, they are so expensive that the lower-income groups, who need this care the most, cannot afford to subscribe.

Government aid for special programs

George Washington was still alive when the Marine Hospital Service for sick merchant seamen (now the United States Public Health Service) was established. Since that day a variety of tax-supported health services have one by one been added to the functions of government. Local and state governments and, to a minor degree, the federal government provide funds for a large number of hospitals, public health services, and medical care programs. These funds may be used either to combat particular diseases, such as malaria, tuberculosis, or syphilis, or to give all types of care to certain groups of the population, for instance, veterans, men and women in the Army and Navy, Indians, or the needy.

That such government programs can be successful in delivering medical service of high quality is attested by the brilliant record of Army and Navy medicine in World War II. Official records of the War Department show, for example, that whereas 8.3 percent of the hospitalized wounded, excluding gas casualties, died in World War I, only about 4 percent died in this war. Although warfare in the fever-ridden tropics meant an increase in the number of men hospitalized overseas for disease, the annual deaths from overseas hospitalized illness amounted to only 6 per 10,000 men, as compared with 128 in World War I. Deaths from hospitalized illness in the continental United States accounted for another 6 per 10,000 men in contrast to 156 in World War I.

Such results are to be explained, in part, by recent scientific developments like penicillin, the sulfa drugs, use of plasma, DDT, and airborne evacuation of the wounded. But even these discoveries could not have been made effective without good

organization, good direction, good equipment, good doctors and nurses, and good use of doctors and nurses.

Not all government-aided medical programs have the enviable record of the Army and Navy, but they have met important special needs. Nevertheless, for the total civilian population, these special programs do not meet other equally pressing needs. There are, and will continue to be, all sorts of proposals to fill in the gaps between existing tax-supported services.

The new tuberculosis control law is a good illustration of how an established state program can be expanded by the use of additional federal funds. An all-inclusive service of early diagnosis, hospital care, and rehabilitation is being developed from a meager program of treatment.

Venereal disease clinics in a way fit into state mental hospital programs. Early discovery and treatment of syphilis at a clinic can free from this disease vast numbers who might otherwise end up in mental institutions twenty years later.

Other diseases might be attacked in the same way through use of tax funds. Rheumatic fever, for one, which every year kills more children than all other childhood infectious diseases combined, might be much reduced in amount and severity by a concentrated program of attack.

Government aid will undoubtedly be requested for other special groups of the population. For example, tax funds might be sought to help needy parents provide their children with the medical and dental care recommended by school doctors or to help care for the needy in nongovernmental hospitals.

The necessity for many such special programs is generally recognized. Few attack them as undesirable, yet it is frequently felt that approaching the problem of medical care in this piecemeal fashion, disease by disease or by one special population group after another, is unsound. This approach, it is said, has led in the past to a piling up of agencies having to do with medical care—some local, some state, some federal.

Each has different standards and differing procedures for the patients to go through before securing care and which the doctors must follow before getting paid. Many, such as public city hospitals, are still run as charities which most people use only as a last resort.

Tax-supported services are so scattered and uneven that most people don't even know which ones they are entitled to use or how to go about getting them. Under most such programs, the patient must in effect prove that he is entitled to care not just because he is sick, but because he is eligible to become a beneficiary under some particular law.

As new health programs are added, critics of the piecemeal approach maintain, it is increasingly important that they fit into an organized system and not bring along their own particular brands of red tape. "There is no functional or administrative justification," says the American Public Health Association, "for dividing human beings or illnesses into many categories to be dealt with by numerous independent administrations."

The A.M.A. has long maintained that all federal activities in the field of health should be brought together in a single government agency, headed by a cabinet member, instead of being scattered among different departments and agencies. Such a move might be beneficial in tying together some of the federally supported services, which, except for the Army and Navy, form a relatively small part of all tax-supported activities. But many feel that no fundamental change would be achieved by such a move alone. Confusion in the administration of existing health services is the inevitable result of a variety of laws and allocations for strictly limited purposes, they say. Until a person is entitled to medical care just because he is sick, and not because he is a sick soldier, or a sick Indian, or a sick orphan—until then there is bound to be a variety of standards and procedures to fit the needs of each separate program.

So, while some groups want no further government action and others see the role of government limited to special programs where there are certain dramatic health needs, still others feel that an over-all national health program is the only satisfactory way to assure good medical care to all who need it.

A nation-wide health program

What do those who want an over-all health service plan have in mind? Two reports have recently been published outlining the principles under which the respective backers believe progress in national health can best be achieved. One is a statement of the American Public Health Association (A.P.H.A.), a second is a report of the Health Program Conference, a group of physicians, economists, and others interested in progressive health planning. These are not, of course, the only documents ever brought out in favor of a national health program. The demand goes back many years and has taken many forms. These two reports are used to represent the all-out program here because they are recent, comprehensive, and authoritative.

Neither report came out with a model law, in fact neither group supposed that a single law would cover all its recommendations. The reports were designed instead as guides to future action. Their goal is the same—a plan which would make good medical care, preventive, diagnostic, and curative, equally available to all the people, in all areas of the country.

Why national?

A comprehensive health plan must be national in scope, according to the views expressed in both these reports. Health programs organized on a state-by-state basis, with no federal aid, they maintain, would fall into the same unequal pattern as at present. The same economic factors which make some wealthy states able to maintain good private and public health facilities would also lead to successful health plans in these

areas. And the relative poverty of other states, which is now reflected in their scarcity of doctors and hospitals, would likewise mean very inadequate health plans among them.

The A.P.H.A. and Health Program Conference reports also maintain that certain national standards are necessary to make sure that the quality of medical service everywhere meets at least minimum requirements. Because people in our country are always moving from place to place, national standards for the amounts and methods of payment to hospitals and doctors, conditions of service, and adjustment of complaints would also be desirable, they say. These, however, should be administered in a way that would take account of the differences in requirements between various parts of the nation, they agree, because a health program in the hills of Kentucky, for instance, would present vastly different problems from a health program in Seattle.

Critics of a national program say that it would mean regimentation. In their view, it would be better to have state programs, even granting that the people in some states would be far better served than in others, rather than to run the risk of rigid government control.

Both reports assume that government regimentation is by no means inevitable if, in the framing of laws, flexible administration is recognized as all important. They agree that actual operation of a health program must be directed largely in each individual community and state, and the program should be responsive to local needs. Strictly medical matters must be kept in the hands of the medical profession, which alone is competent to set medical standards, they say, and questions of public concern, such as financing and distribution of services, must be in the hands of the public.

Concluding that a wholly satisfactory health program must be nation-wide in scope, the A.P.H.A. and the Health Program Conference reports go on to outline what seem to them the essentials of any such plan.

WHAT ARE THE PILLARS OF A NATIONAL HEALTH PROGRAM?

FIVE KEY PILLARS are necessary to support national health, according to these reports. They are: (1) distribution of the costs of health services, (2) establishment of hospital and public health facilities, (3) organization of medical services to promote a high quality of care, (4) administration satisfactory to patients and the professions, and (5) promotion of continued scientific research and education.

Distribution of costs

Starting out with the twin assumptions that the present individual pay-as-you-go method of meeting medical costs has proved itself unsuited to the needs of the population and that voluntary insurance is too limited in scope, advocates of a national health program recognize two alternative ways of meeting medical costs. Both methods of payment are based on the fact that while individuals can never predict when they will be sick or how expensive their illnesses will be, the expected incidence of illness for large groups of people and its costs can be fairly well determined. By chipping in regularly to a common pool amounts which are fair in pro-

portion to his income, each member of the large group can be sure that there will be funds to pay for his own health needs, whether large or small, whether they occur next year or tomorrow.

The first alternative is a system of national health insurance, combined with support from general tax funds. This method is advocated in both reports. National health insurance is no new thing, in fact it is in operation in thirty-one nations. In some it is over fifty years old. It works like this: Employed people turn in a certain part of their wages each month, through payroll taxes, to a government-administered health insurance fund. Employers match the amounts each worker puts in, as under Social Security in the United States. When sickness strikes the wage earner or his family, doctor and hospital bills are paid out of the insurance fund.

Insurance of this type was designed originally for the wage earner, whose premiums can be easily collected through payroll deductions and for whom employers can also make their contributions easily. Such health insurance in other countries has seldom been available to farmers, people who run their own small businesses, domestic servants, and other similar occupation groups. Health insurance on this plan does not touch the sickness costs of nonworking people—the unemployed, the aged, the chronically ill. For this reason both the A.P.H.A. and the Health Program Conference reports recommend that, if national health insurance is adopted, it be supplemented by general tax funds to include all groups of the population.

The second alternative method of financing, suggested by the A.P.H.A., is that the insurance features be forgotten and public health services be paid for simply and solely out of taxes—just like public schools. This, it is argued, would involve far less red tape. All groups of the population would pay for their health services by the same kind of taxes. The

amount would vary according to the particular circumstances of the individual. Great Britain, which has had national health insurance since 1911, is planning a system in which two-thirds of the costs will be financed through general taxation along these lines.

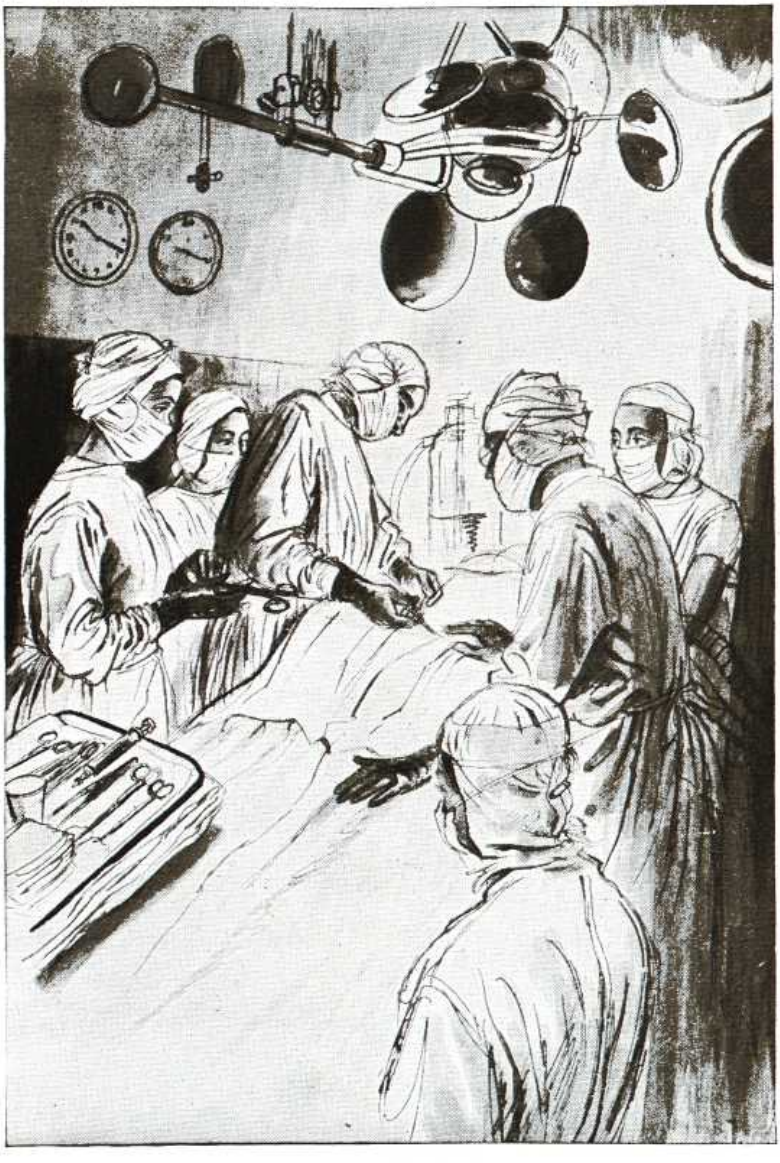
Whichever may be the better way of enabling people to pay for medical care—whether by health insurance combined with taxation or by taxation alone—the reports of the A.P.H.A. and the Health Program Conference agree that as long as payment is made in the manner of today, the "right to achieve and enjoy good health" will not be truly available to all, and that some such nation-wide solution must be found for the problem.

But a method of paying for medical care is only part of the story. With a thousand dollars in his pocket, a man on a desert island with no doctor or hospital could still not get his broken arm set. Both the A.P.H.A. and Health Program Conference plans emphasize the need for construction of facilities in areas which lack them and improvement and enlargement of facilities where they are inadequate.

Facilities and personnel

The keystone here, according to both reports, is the hospital. A hundred years ago the hospital was mainly a place for the sick poor to go, often only to die. Today, the hospital is a place to which any sick person goes to get modern treatment, and it is a place where he expects to get well.

The hospital is indispensable in practice to the provision of good medical care—yet 40 percent of the counties of the United States have no recognized hospital facilities. This situation would be bad enough in itself; yet it is also reflected in the number and kind of physicians such counties can attract. Younger physicians whose education and training is centered in well-equipped and well-organized hospitals cannot practice



the kind of medicine they have so painstakingly learned in school unless there is a hospital to work in.

The result is that counties with no general hospitals have only half as many doctors per thousand inhabitants as counties of the same income level which are generously supplied with hospitals. Since counties lack hospitals directly in proportion to their inability to support them, those who favor a national health program think that federal funds should be used to construct, enlarge, and modernize hospitals in the poorer counties.

The A.P.H.A. report, in addition to urging hospital construction, stresses the need for public health departments to serve all areas of the country. At present, 1,223 of the nation's 3,000 counties lack any organized health department.

The need has long been generally recognized for health departments to insure safe water and milk supplies, sewage disposal, and control of communicable diseases, and for health centers where special clinics can be conducted, such as those for maternal and infant care or diagnosis and treatment of venereal disease. The A.P.H.A. report again emphasizes this need and concludes that it should be woven into a national health program.

Both reports assume that modern hospital and public health facilities, combined with improved methods of paying for needed medical services, would, to a certain extent, automatically attract doctors, dentists, and nurses to areas which are now greatly undersupplied.

Organization of services

With a fairer way of paying the health bill and with hospitals and medical personnel distributed according to where they are needed, many of the objectives of a national health program would be realized. What about the quality of this care? Obviously, quality under any system of financing is, in the last analysis, what the individual doctor, nurse, dentist, or laboratory technician makes it. Nevertheless, certain methods

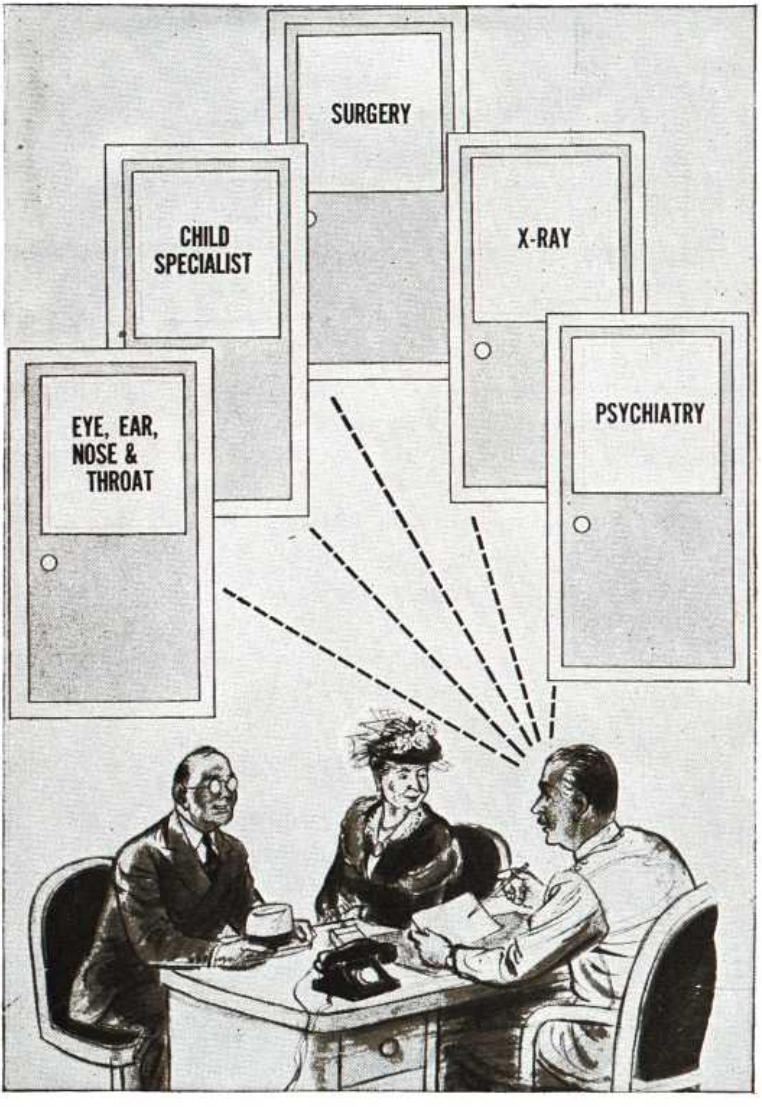
of organizing professional services tend more than others to encourage advances in quality.

The report of the A.P.H.A. and, more particularly, that of the Health Program Conference, stress encouragement of better professional organization as another essential of a national health program. The focus here, again, is the hospital but a hospital that functions in a new and different way. It is to become not only a place where illness is treated, but also a center for preventing disease and for improving the whole practice of medicine in the surrounding area. It is suggested that such a truly modern hospital could, in addition to its usual facilities, house public health clinics, the offices of physicians and dentists, and equipment for the common use of all. In such a group-practice unit, doctors would be encouraged to work more as a team, pooling their knowledge and skills.

Group practice

The general physician, it is assumed, would be the patient's main source of medical care. But at his elbow would be the hospital and the specialists whose services are necessary if he is to practice modern medicine. Freed through health insurance from the responsibilities of fee setting and bill collecting, the family doctor might, for example, find more time to act as guide and counselor in the emotional problems of his patients as well as providing them with other types of medical care. His role in the prevention of mental illnesses, one of our biggest unmet health needs, might be strengthened through the advice and teaching of his colleagues in psychiatry.

Working in groups, doctors are to some extent supervised by each other in the kind of services they render. For example, a young surgeon in a group is usually assisted by a more experienced colleague when undertaking an especially ticklish operation. The story leading up to the death of any patient is reviewed at staff meetings. These supervisory practices are not a new idea; they have been used for years in good hospitals



Group medical practice brings your doctor into close working association with other doctors of different interests and skills.

to safeguard the quality of medical service, especially for ward cases.

Such supervision does not require an outside government inspector. Under any health program it could be carried out, as at present, by groups of physicians themselves. Indeed, as mentioned before, group medical practice is no new idea, but a familiar phenomenon in the private group clinics scattered throughout the United States, particularly the middle western and western states. What is new in the Health Program Conference report is the idea of encouraging this type of organization throughout the nation, and combining it with a more favored place for the family doctor than exists now either in individual or in certain types of group practice.

A network of hospitals

Towns and cities of different types, sizes, and locations naturally require different sized hospitals and differently equipped hospitals. The country hospital, for example, could never make enough use of radium to justify the expense of owning it. A thinly populated area may need a highly trained brain surgeon only once or twice a year. Nevertheless, when these and other unusual services are needed, they must be accessible. What is the answer?

Both reports endorse a plan of organization somewhat similar to that of Army hospitals. They would encourage future construction of hospitals according to an integrated scheme of health centers (corresponding to the Army field station)—rural hospitals, district hospitals, and base hospitals.

To illustrate: A state might have one or more *base hospitals*, preferably connected with medical schools, where all types of medical service would be available and where the more unusual types of treatment would be carried out. Here, where they could answer any need in the state, would be the brain surgeons and the radium. Base hospitals would also be centers of teaching and medical research.

The many *district hospitals*, located in large towns or cities, would be large, and equipped to handle the more usual medical and surgical cases. Smaller *rural hospitals* would be far more numerous than at present and would be designed to take care of ordinary diagnosis and treatment, minor surgery, obstetrics, and so forth. They would refer complicated conditions to the district or base hospitals. Health centers, spotted about hospitals of all types, would house the offices of public health nurses, laboratories, public health clinics, doctors' offices, and some emergency beds.

Patients would, as a rule, go to the hospital nearest home, but for particularly difficult types of diagnosis or treatment might go to a base hospital, much in the same way that those who can manage it now go to a well-known clinic or medical center.

This scheme of integrated hospitals would make constant exchange of information, training, and personnel among them possible. On this foundation, a consultation service could be built so that at regular intervals specialists from the larger hospitals would visit rural hospitals and health centers. At the same time, rural physicians might go up to the base hospital for special postgraduate training, returning to their practice stimulated and better prepared.

Proponents of a nation-wide health program see in hospital organization along these lines a tremendous inducement to physicians to organize themselves into strong professional groups. Whether or not doctors would wish to take advantage of these opportunities would of course remain to be seen. There are indications that younger members of the profession, in particular, would welcome the chance.

Administration

How could such a program be carried out so that both the patients who receive the services and the doctors, dentists, nurses, hospital people, and others who render the services

would be satisfied? Here, the guiding principle, both reports agree, is that while the health program should be national in scope and while certain national standards are necessary to insure that public funds are used to best advantage, nevertheless the responsibility for the detailed planning and working of the program must rest with local areas.

For example, the federal government might refuse to allot national health funds to hospitals without laboratories. Few would question that such minimum standards should be set. On the other hand, the government would not be similarly justified in trying to tell doctors when to use a particular kind of laboratory test. Such judgments must of course be made by the doctor himself, subject to the staff regulations of his fellow physicians in the particular hospital.

Except for professional questions, the lay public, which receives it, should have a strong say on how the service is conducted, both in their own communities and at the state and national levels.

Certain freedoms are considered basic:

1. *Patients* should be free either to make use of services provided under the national program or to continue to secure medical services in the traditional manner, as they prefer.

2. *Patients* should be entitled to choose among individual physicians, organized groups of physicians, hospitals, and so forth. Likewise, they should be free to change their sources of service without difficulty.

3. *Physicians* should be free, as they now are, to accept or reject patients; to participate or not to participate in a national program; to furnish services as individuals or to associate with other physicians in groups.

4. *Voluntary agencies* (such as hospitals) should be encouraged to participate in the national program, maintaining their status as independent agencies and retaining full responsibility for their own administration, or not to participate in the national program if that is their preference.

Incomes of physicians

Neither the A.P.H.A. nor the Health Program Conference report offers a pat solution to the thorny question of how doctors should be paid. They agree that medical services should be provided as economically as is consistent with high quality. At the same time they feel that remuneration to doctors should be sufficient to attract and hold good men and should be scaled so that there are financial rewards for professional excellence.

There are three principal ways doctors could receive payment under a national health program. The health fund could pay doctors in individual practice: (1) a fee for each service rendered to patients, in the same way that most doctors now collect fees from their private patients, or (2) a set amount per year, called a "capitation fee" for each person choosing the doctor's services. Doctors working together in group practice could be paid by salaries from their groups. In such cases the health fund could pay (3) a lump sum to the organized group, determined by the extent of medical service the group provided or the number of patients using it.

Although fee-for-service is most used in private practice today, there are also many physicians in the United States who are paid by the other methods and apparently find them satisfactory. When faced with the prospect of payment by the government, however, doctors are naturally concerned lest they be underpaid. Medical education is expensive, and it takes a number of years after graduation before doctors begin to earn a living by their practice. It is natural for doctors to wonder whether a government system would offer a reasonable income. The example of poorly paid schoolteachers, government clerks, public health nurses, and "city physicians" does not reassure them. Many people feel that the question of payment to physicians lies at the heart of doctors' opposition to a national health program.

Both the A. P. H. A. and the Health Program Conference reports agree that there is room for experimentation with methods of paying physicians, but argue that a physician's yearly income must be adequate, as measured by the incomes usual among other physicians of the same age and training and in the same type of community, and by the incomes of other professional groups.

Research and education

Under any type of health program, the quality and the continued improvement of medical services lean heavily on research and medical education. The half billion dollars invested in these fields by private philanthropy over the last fifty years are held to be largely responsible for the high place of American medical science today. Advocates of a national health program say that government funds must be forthcoming where private funds leave off if knowledge is to march steadily forward. In fact, during the war, the federal government sponsored and in many cases subsidized both medical and nursing education and a variety of scientific research. The results—for example, discoveries as to the processing and uses of stored blood—are familiar enough to those in the armed forces.

In addition to funds for research, the Health Program Conference report emphasizes the need for more opportunities for postgraduate training for physicians. Medical science advances so rapidly that the physician who graduates from medical school this year will find it necessary next year to bring himself up to date. Too often the busy practitioner has no time to keep up with advances through study and reading; rarely is he in a position where he can afford to take a month off for postgraduate study. This is particularly true of the country doctor. Opportunities for doctors to get postgraduate medical education could be greatly furthered by the use of public funds, advocates claim, although even more important

The charity clinic and the visiting nurse are often the only sources of medical service to the poor and the isolated.

day-by-day results would be obtained through improved organization of medical services.

The OSRD report

The use of federal funds to support a program of scientific research was recommended to President Truman in July 1945 in a report of Dr. Vannevar Bush, director of the Office of Scientific Research and Development—the government agency responsible for the use of federal funds for such research during the war.

In this report the war against disease is given first consideration. Dr. Bush strongly advocates government support of medical research as basic to any national program of expanded medical training and research and to the promotion of public health.

The report, which recommends the establishment of a national scientific research foundation responsible to the president and Congress, was received with widespread public interest.

HAS A NATIONAL HEALTH PROGRAM BEEN PUT BEFORE CONGRESS?

DO THESE PRINCIPLES of a national health program appear in practical form in the legislative proposals brought before Congress? What manner of national health program is it anyway that has been advanced for public discussion and eventual Congressional decision?

Beginning in 1943 with the original Wagner-Murray-Dingell Bill to add health insurance to the Social Security system, several bills have been proposed embodying the principles. They include the Hill-Burton Hospital Construction Bill, a new version of the Wagner-Murray-Dingell Bill introduced in May 1945, and a still later revision of November 1945.

The first Wagner-Murray-Dingell Bill

National health insurance was but one of several provisions of this bill. Other provisions, such as extension of Social Security, the nationalization of unemployment compensation, and federal aid for general relief, are beyond the scope of this discussion.

The bill provided that health insurance would be established by the creation of a national medical care and hospitalization fund, to which employers and employees would each contribute 1.5 percent of the first $3,000 of annual wages, making 3 percent in all. Self-employed would contribute the entire 3 percent themselves. Contributions amounting to an additional 4.5 percent of wages would be made by employers and employees, 9 percent in all, to pay for the other benefits of the bill. Two of these latter provisions have an important bearing on health, namely, those providing for cash payments during temporary and permanent disability.

For every insured person and his family, the medical care and hospitalization fund would pay for unlimited doctors' care including specialists, for hospitalization up to 30 days, X rays, and laboratory tests. Dental care, nursing, medicines and drugs would not be paid for.

Patients would be free to choose their physicians from among those participating in the program, whether engaged in individual or group practice. Standards of competence for specialists and hospitals would be established by the Surgeon General of the United States Public Health Service. Any licensed physician could participate in the program as a general practitioner.

The national fund would pay physicians for the services rendered to patients covered by the system through any of several methods—fee-for-service, capitation, part-time or full-time salaries, or by a combination of these methods. The physicians of each area would choose by majority vote the

method of payment to be adopted in that area. Hospitals would be paid up to $6 per day for each day of care they furnished.

Reaction to the bill

The 1943 Wagner-Murray-Dingell Bill never came to a vote in Congress. Nevertheless it caused a storm of comment. Backed enthusiastically by organized labor and some farm organizations, it was considered by them "so enormous an improvement over our present social security provisions that no responsible person, deeply concerned with the welfare of our country, can fail to support it."

At the same time, it was vigorously opposed by representatives of organized physicians, in whose minds it was "socialized medicine." The opposition groups said that the bill implied that sick people would have to depend on a doctor paid by the government to work only eight hours daily—emergency cases would have to wait until the doctor checked in. Patients would have to go to the doctor assigned to them by political bureaucrats, and doctors would become incompetent because methods and remedies would be fixed by bureaucratic superiors. Largely to oppose this bill, physicians and drug houses raised and spent over a quarter of a million dollars in giving out "information" of this nature. Extremes were reached with statements like, "It is doubtful if even Nazidom confers on its gauleiters the powers which this measure would confer on the Surgeon-General of the U. S. Public Health Service."

One group of physicians attempted to promote a national movement to boycott any legislative program such as the Wagner-Murray-Dingell Bill, giving physicians this advice: "If such legislation as the Wagner-Murray-Dingell Bill passes and your patients come to you for services under the plan, tell them you don't serve the politicians, you serve them. If they want to know what they are going to get for the money

deducted from their pay checks for health insurance, you don't know."

It is of course debatable whether an insurance scheme such as that proposed in the bill would in fact have the disastrous effects predicted by its opponents. Certainly the bill itself had no provisions for assigning patients to doctors, for regulating physicians' hours of work, income, or methods of practice, except for the elementary requirement that specialists meet national standards of competence in their particular fields.

Many persons in favor of federal legislation for health and medical care felt, however, that the first Wagner-Murray-Dingell Bill fell far short of providing a truly adequate health program for the nation. They pointed out that it included, for example, no provision for the construction of hospitals and health centers. It contained nothing to encourage the expansion of preventive health services. It offered nothing to induce physicians to modernize their methods of practice by joining together in groups instead of continuing in the traditional solo practice of the old-time family physician.

Some felt, too, that the whole population should be protected under the plan, rather than merely employed persons and their families. For this reason, and to promote preventive health services, support from general taxes as well as from the payroll contributions of employer and employee was urged.

Finally, disinterested critics generally felt that the bill permitted too centralized an administration of the program. They said that the program did not require sufficient participation by state and local governments nor by local representatives of the professions and the public. The American Bar Association made the additional point that it failed to provide for court review of administrative decisions.

The new Wagner-Murray-Dingell bills

A revised Wagner-Murray-Dingell Bill, introduced into Congress in May 1945, proposes a pattern essentially similar to

the earlier one, but has added features which meet some of the criticisms made of the original. It had not been acted upon when President Truman sent to Congress his special message of November 19 asking national health legislation.

The President strongly advocated a program of five related proposals for action by the federal government:

1. Financial and other assistance for the construction of hospitals and other health facilities where they are most needed.
2. Increased grants to the states for public health services and maternal and child health care programs.
3. Support of medical education and research.
4. Expansion of compulsory insurance under the Social Security system to cover medical, hospital, nursing, laboratory, and dental care.
5. Cash benefits to cover some of the wage losses during periods of sickness and disability.

In order to meet, at least in part, the President's request, Senators Wagner and Murray and Representative Dingell promptly lifted, rewrote, and introduced as a separate bill the health provisions of their earlier measure.

These health provisions include, besides medical care insurance, increased federal grants to the states for public health work and for the care of mothers and children, but no funds for construction of hospitals and health centers. Benefits of the medical care insurance have been increased by adding limited home nursing and dental care. An attempt has been made, too, to increase the responsibility of states and communities through advisory committees, although the final administrative control remains in the federal government. Court review of administrative decisions is, however, specifically authorized.

Groups of physicians, as well as individual practitioners, may participate in the plan but they are not expressly encouraged. The physicians of an area may still decide by vote

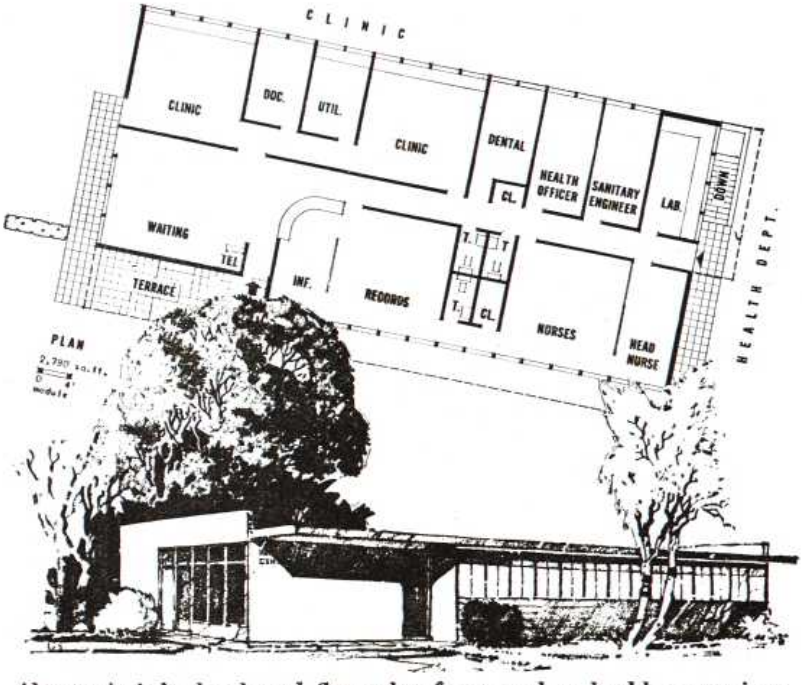
how they wish to be paid, but such a vote is no longer binding upon all the doctors of the area. General taxes are to be used more generously to supplement the funds contributed by employers and employees, but the plan does not yet cover the entire population.

Summary of opinion

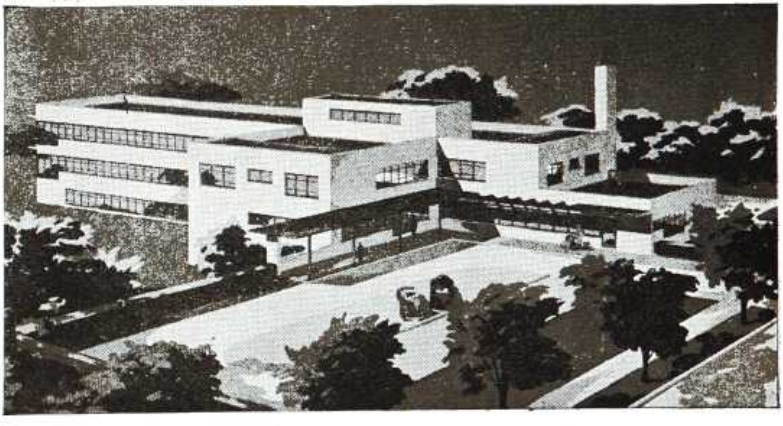
Discussion of national legislation for health will doubtless be focused about the Truman proposals and the latest Wagner-Murray-Dingell Bill for some time to come. It will be useful, therefore, to repeat the principal arguments for and against the original bill. The groups supporting the 1943 measure emphasized the necessity for nation-wide action in order to equalize the opportunity for health services among all groups of the population in whatever part of the country they happen to live. They also stressed the need for a method of paying for medical service by which people can pay in known, regular amounts, month by month, in accordance with their earnings.

Those opposed to the first bill, on the other hand, made an issue of the danger of political control over medical matters, of a possible threat to the individual freedom of patients and doctors, and of the limitations that it might impose upon physicians in professional status and—by implication—income.

The nation-wide discussion that took place as a result of the introduction of the bill had broad educational value. It stimulated people everywhere to greater awareness of the issues. It provoked painstaking inquiry by numerous nonprofessional organizations and groups as to the true facts of medical care in their own communities and in the nation as a whole. All this served in some degree to clear the air, to dispel false notions and groundless fears, and to aid the country in facing realities. With this increased interest and knowledge as a background, the public is better prepared, with the introduction of the November 1945 bill, to resolve differences of opinion and to focus its attention upon specific points for action.



Above: Artist's sketch and floor plan for a modern health center in a community of 30,000. Below: Sketch for up-to-date fifty-bed hospital in a community of 10,000 to 20,000.—*U. S. Public Health Service.*



The Hill-Burton Hospital Construction Bill

This measure, introduced in the spring of 1945, would provide federal grants to states for the construction of hospitals and health centers. Designed to encourage over-all planning by the states of an ordered network of health facilities, the bill calls for each state to study its existing hospital resources and unmet needs, in order to develop a master plan of construction. The federal treasury, after state plans had been approved by the Surgeon General of the United States Public Health Service, would supplement funds for construction raised within the states, paying a larger share of federal funds in poorer states, and a smaller share in richer ones.

Besides providing for the construction and improvement of state, city, and county hospitals for general care, mental illness, and tuberculosis, this bill would also aid in the construction of those nongovernmental community hospitals which are not operated for profit.

Supported by the American Hospital Association, organized labor, farm groups, and the American Medical Association, this bill has aroused little opposition. It fits into the principles of a national program in the following ways:

1. Differences between states in availability of hospital facilities might be greatly lessened because national tax funds would share the costs of construction.
2. Improved organization of services centered around hospitals is made possible if hospital administrators, physicians, and the public wish to avail themselves of the opportunity, because construction would be based on state-wide planning.
3. Decentralized administration within the states, subject only to general national standards, would reflect the particular needs and circumstances of the various states and communities.
4. The principle that private, nonprofit agencies can maintain individuality within a national, tax-aided program is recognized by the inclusion of improvements and new construction for this type of hospital.

The bill, however, is criticized to some extent by farm and labor groups because the general public, who would use the

hospitals, would not have a great deal to say about where they are to be located. As provided in the bill at present, the committees who determine the location of the hospitals would be composed largely of hospital administrators and physicians.

The most serious criticism of the Hill-Burton Bill is that it can meet only limited needs. It does not attack the problem of paying doctors' and hospital bills. A modern, well-equipped hospital is of little value to a community if the people in that community cannot afford to use it. At present, it is the sad truth that areas which have the least hospital facilities in proportion to population are also the areas where such hospitals as do exist are the least used. In other words, where communities are too poor to build adequate hospitals, the people living there are too poor to pay for hospital care under present arrangements. To guard against the possibility of putting up white elephants, in the shape of hospitals which would not be used, this bill provides that communities wanting new hospitals must show ability to support them after they are built. If this cannot be shown, no federal money would be forthcoming.

Were the Hill-Burton Bill passed in this form—and in the absence of any measure to meet the patient's problem of paying hospital charges—some critics think that most new hospitals would be built in wealthy areas which need them less than other localities but which can afford to support them after they are built.

The Hill-Burton hospital construction bill is of great significance because it is the first national measure related to medical care which has received support from all major professional groups as well as major farm and labor groups. Yet even its most ardent sponsors recognize that at best it can meet only limited needs as long as the problems of paying doctors' and hospital bills are still unsolved and that at worst it might result in an even less equitable distribution of general hospital beds than at present.

WHAT IS THE A.M.A. PROGRAM?

In July 1945 the American Medical Association announced its program to meet the admittedly unsatisfactory health situation in America. This program emphasizes the need for intensification of voluntary efforts to solve the problem of paying the medical bill. Sustained industrial and agricultural production is urged to improve living conditions and therefore health conditions. State surveys are suggested to determine the need for additional medical care and to appraise the adequacy of voluntary insurance plans in meeting such needs and in improving the quality of medical service. Extension of preventive public health services to all parts of the country is advocated. The expansion of voluntary insurance against the costs of hospitalization and physicians' services, so as to serve all communities, is proposed.

The A.M.A. report further suggests that the medical care of the needy be met from local tax funds paid as premiums to voluntary sickness insurance plans directed by doctors. Supplementing state and local funds by national tax funds is proposed where definite need for such aid is demonstrated. Emphasis is placed upon the importance of informing the public about the nature of voluntary insurance plans, with recognition that they need not involve any increase in taxation.

Finally, the report urges postponement of the consideration of "revolutionary changes" while large numbers of men and women, including medical officers, remain in the armed services, and proposes measures for rectifying the present and future shortage of medical personnel, particularly in rural areas. The question of the organization of medical services around a network of hospitals, or in group practice, is not touched in this report.

WHAT ARE THE MAIN ISSUES?

PUBLIC DISCUSSION in recent years indicates widespread concern about the quality and distribution of health services in the United States. Five principal problems are generally recognized:

1. How to arrange payment so that all the people can regularly pay specified amounts in accordance with their earnings rather than be burdened irregularly and unexpectedly with the large costs of unpredictable illness.

2. How to pay for medical services and facilities so that they can be available more evenly throughout the country.

3. How to organize America's health services to use our medical resources most effectively and furnish service of high professional quality.

4. How to make necessary changes and yet preserve the best of our present medical practice, avoid undesirable and arbitrary governmental controls, and guarantee freedom within the program for both patients and physicians.

5. How at the same time to stimulate continued and improved medical education and research.

Although there is much disagreement as to how it should be done, most groups of the professions and the public appear to agree on the basic principles that people can more easily pay for medical service by some type of insurance than by the traditional fee-for-service method; that federal funds from general taxation will be needed if hospitals and other facilities are to be built in needy areas; that medical services can be supplied more economically and with better guarantee of quality by the use of group medical practice than by individual practice; that local representatives of the professions and the public must control the distribution of services on the basis of broad national standards; and that national funds will be needed to support improved and extended medical education and research.

Controversy has been most pointed about the proper role of government in any changed organization of health services. Opinions range from those who would limit government aid to specific problems—such as sanitation, communicable disease control, the care of the needy, institutional care for mental illness and tuberculosis—to those who would have government, particularly the federal government, take steps to assure adequate health and medical services to all.

TO THE DISCUSSION LEADER

EVERY HUMAN BEING is faced with the problem of his own personal health. The head of a family has the added responsibility of looking after the health of his wife and children. Civic-minded individuals recognize that health is also a community concern—that good health for the individual often depends on improving health conditions and health standards for the community.

This pamphlet presents major points of view on the important question of improving health. It does not try to give an answer. That is something for the individual to think through for himself.

It is doubtful whether any reader of this pamphlet or any member of a discussion group would argue against the improvement of health. Discussion leaders will encounter plenty of conflicting opinions, however, when they raise the question of *how* health can best be improved. This question of *how* it should be done is something to talk over at your discussion meeting on the basis of the soundest information available.

How can you plan a discussion meeting?

Discussions are ideas in action. You cannot have a lively voluntary discussion unless you bring together individuals who are interested in a subject. Therefore, you need two things: a subject that will interest some people very much, and a means of letting people know that a discussion meeting is to be held on that subject.

"Is Your Health the Nation's Business?" is a subject that will probably interest many people.

Your first major task as a discussion leader, therefore, is to let people in your area know that you are planning a discussion meeting on health.

How can you do this? There are several possibilities. You can show a copy of this pamphlet to the editor of your local newspaper and explain to him the type of program you are planning. You can prepare notices to be placed on bulletin boards. You can prepare posters for reading rooms where you have placed copies of this pamphlet. You can suggest that local librarians arrange reading table displays of this pamphlet and other suggested reading material on public health. Finally, you can "talk it up" to certain individuals who will pass the word along to their friends that a discussion meeting is going to be held on this subject. This procedure on your part will give people who are interested an opportunity to plan to attend your meeting.

What kind of discussion works best?

Each discussion leader is probably his own best judge as to what type of discussion will be most satisfactory for his group. If you are in doubt you might discuss this matter with qualified advisers. In making this decision you should consider several important factors. How large will the discussion group probably be? What kind of facilities are available at the meeting place? What type of discussion has proved most popular with local discussion groups in the past? What good speakers might be obtained for this particular subject?

You should be certain that you understand the general advantages and disadvantages of various types of discussion. Forums, panel discussions, symposiums, and general group discussions are the forms most frequently used. EM 1, *Guide for Discussion Leaders*, tells just how they differ from one another. Below are some specific suggestions.

Forum: A competent doctor who is a good speaker might make an excellent forum speaker on health. One who has had both civilian and military experience in dealing with health problems might be particularly well qualified. After his pre-

liminary talk on health, members of your group could question the speaker on points of particular interest to them.

Panel Discussion: Health is a subject that would lend itself particularly well to a panel discussion if you can get four or five qualified speakers. A group of young doctors, or a combination of doctors, dentists, and psychologists, might make a panel that would keep the discussion ball rolling in a lively manner. Time should be allowed for members of your group to question the panel participants.

Symposium: Two or more doctors, particularly those with diverse ideas about *how* to improve health, would make good symposium speakers. You should limit each to about ten minutes so that members of your group will have an opportunity to question all the speakers.

Informal Discussion: Since health directly concerns every individual and each has his own ideas about maintaining health, your entire program could be conducted as an informal discussion. It will be necessary for you, as discussion leader, to be familiar with the contents of this pamphlet and to be prepared with well-organized questions to bring out major health issues for discussion.

Can discussion handbooks be helpful?

Discussion leaders will find many helpful suggestions on planning and conducting discussions in EM 1, *Guide for Discussion Leaders.* This *Guide* discusses in detail the various types of discussion possible. It gives helpful hints on handling difficult personalities at discussion meetings. It emphasizes the importance of careful planning and outlining a program of discussion. Study of this handbook will enable a discussion leader to improve his program; it challenges him to use his own ingenuity to make his program interesting and worth while.

Some discussion leaders face the problem of planning and conducting programs to be broadcast over the radio or on a

loud-speaker system of Armed Forces Radio Service. They will find EM 90, *GI Radio Roundtable*, full of sound advice and usable suggestions.

Questions for discussion

You should jot down your own questions as you read this pamphlet and outline your discussion program. You should encourage members of your group to ask questions. Sometimes the most helpful questions grow out of the discussion itself. It is well, however, to be prepared. Below are some questions which you may find helpful.

1

Has civilian medical care been accessible and satisfactory to members of the discussion group and their families? Has the problem of payment for physicians' care or hospitalization been difficult? Have doctors and hospitals been located reasonably near at hand? Has it been easy or difficult to obtain the services of necessary specialists? Why?

2

Would the problem of payment for medical service be eased by insurance against the costs? Do you think voluntary insurance against the costs of sickness can provide a satisfactory solution for the problem of payment throughout the country? In urban communities? In rural areas? In all geographical areas?

3

Would there be professional advantages in a scheme in which physicians practiced in groups? Economic advantages? From the patient's point of view? From the doctor's point of view?

4

How do the advantages and disadvantages of medical practice in the military services compare with those of present-day civilian medicine? From the patient's point of view? From the doctor's point of view?

5

Is the normal peacetime distribution of civilian physicians and hospitals satisfactory? What factors influence this distribution the most? Could they be modified by physicians? By the public? How?

6

What measures have recently been proposed by the American Medical Association to meet the nation's health needs? What effect do you think these proposals, if carried out, would have upon (a) the ability of people generally to pay the costs of sickness? (b) the distribution of doctors' and hospital services? (c) the quality of medical and hospital services?

7

Do you think the United States government should (a) do nothing further in the health field? (b) support only special health programs such as those to benefit mothers and children or combat venereal disease, tuberculosis, and mental illness? or (c) sponsor national action for health care on a broader basis by insurance or tax support? Would action by the federal government tend to improve or lower the quality of medical care received by people generally? Why? Would most doctors benefit or suffer economically and professionally as a result of federal action? Why?

8

Should the federal government aid in the construction of hospitals where they are needed? How should such hospitals be supported if built? Who should own them? Who should determine their location? What doctors should be eligible to use them? What patients should be eligible for admission to them? Would hospitals built without federal government aid serve the public better?

FOR FURTHER READING

THESE BOOKS are suggested for supplementary reading if you have access to them or wish to purchase them from the publishers. They are not approved nor officially supplied by the War Department. They have been selected because they give additional information and represent different points of view.

AMERICA ORGANIZES MEDICINE. By Michael M. Davis. Published by Harper and Brothers, 49 East 33d St., New York 16, N. Y. (1941). $3.00.

ORGANIZED PAYMENTS FOR MEDICAL SERVICES. By Bureau of Medical Economics of American Medical Association, 535 North Dearborn St., Chicago, Ill. (1941). Copies no longer available from publisher.

U. S. MEDICINE IN TRANSITION. Article in *Fortune*, December 1944. Reprints available on request from *Fortune*, Empire State Building, 350 Fifth Ave., New York 1, N. Y.

JUSTICE AND THE FUTURE OF MEDICINE. Article by Wendell Berge in *Public Health Reports*, Vol. 60, No. 1, January 5, 1945. May be obtained from Government Printing Office, Washington 25, D.C. 10 cents.

HEALTH INSURANCE IN AMERICA. Published by United States Chamber of Commerce, 1615 H St., N.W., Washington 6, D.C. (1945). Addresses delivered at the Second National Conference on Social Security. Free on request to servicemen.

WARTIME HEALTH AND EDUCATION. Report No. 3 of the Senate Subcommittee on Wartime Health and Education, Senate Office Building, Washington 25, D.C. (January 1945). Free on request.

HEALTH CARE FOR AMERICANS. By C.-E. A. Winslow. No. 104 of *Public Affairs Pamphlets*, published by Public Affairs

Committee, 30 Rockefeller Plaza, New York 20, N. Y. (1945). 10 cents.

PRINCIPLES OF A NATION-WIDE HEALTH PROGRAM. Report of the Health Program Conference, published by Committee on Research in Medical Economics, 1790 Broadway, New York 19, N. Y. (1944). 10 cents.

CONTENT AND ADMINISTRATION OF A MEDICAL CARE PROGRAM. An article by Joseph W. Mountin in *American Journal of Public Health* (December 1944). Reprints available from American Public Health Association, 1790 Broadway, New York 19, N. Y. 25 cents.

VOLUNTARY MEDICAL INSURANCE IN THE UNITED STATES: MAJOR TRENDS AND CURRENT PROBLEMS. By Helen Hershfield Avnet. Published by Medical Administration Service, 1790 Broadway, New York 19, N. Y. (1944). $1.00.

MEDICAL SERVICE PLANS. Report of Bureau of Medical Economics of American Medical Association (1943). Copies no longer available from publisher.

A CONSTRUCTIVE PROGRAM FOR MEDICAL CARE. The official program of American Medical Association, in *Journal of the American Medical Association*, July 21, 1945. See also editorial and article called "Health Insurance" in the same issue.

NATIONAL HEALTH SERVICE. By British Ministry of Health and Department of Health for Scotland. Published by Macmillan Co., 60 Fifth Ave., New York 11, N. Y. (1944). 75 cents.

THE WAGNER-MURRAY-DINGELL BILL—S.1050 OF 1945. An analysis by Bureau of Legal Medicine of American Medical Association, in *Journal of the American Medical Association*, June 2, 1945. See also an editorial on the bill in the same number. Reprints available on request. Much material on the 1943 and 1945 Wagner-Murray-Dingell bills appears in other issues of the *Journal*. See especially an analysis by the

Bureal of Legal Medicine and an editorial (June 26, 1943), and comments by Senator Wagner (June 30, 1945).

AMERICAN BAR ASSOCIATION COMMITTEE REPORTS. In *Journal of the American Medical Association*, March 11, 1944. Reprints available on request.

FOR THE PEOPLE'S HEALTH. Published by Physicians Forum, 71 East 87th St., New York, N. Y. (1945). Free on request to servicemen.

SCIENCE, THE ENDLESS FRONTIER. By Vannevar Bush. Published by Government Printing Office, Washington 25, D. C. (1945). 30 cents.

OTHER GI ROUNDTABLE SUBJECTS

INTRODUCTORY COPIES of each new *GI Roundtable* pamphlet are automatically issued to information-education officers in the United States and oversea areas. Additional copies are authorized on the basis of one copy for each 25 military personnel. Pamphlets may be requisitioned from the United States Armed Forces Institute, Madison 3, Wisconsin, or from the nearest USAFI Oversea Branch. List EM number, title, and quantity. New subjects will be announced as published. *GI Roundtable* subjects now available:

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